Cleveland Sight Center

Facsimile Transmission Form

Low Vision Clinic

Phone# (216) 658-8737 Fax# (216) 658-8731

Date: 3/22/17 Fax # of Recipient: (216) 201-5125

To: GEORGANA KOHLBACHER

From: UNIVERSITY HOSPITALS

Subject: DEBORAH A. MOSS

Number of pages 6 (including cover sheet)

Message:

SHOULD THERE BE ANY QUESTIONS REGARDING THIS MESSAGE, PLEASE CONTACT THE PERSON INITIATING THIS TRANSMITTAL. THANK YOU!!!

Mail address:
P.O. Box 1988
Cleveland, OH 44106-8696

The Cleveland Society for the Blind

EXHIBIT 7

CONFIDENTIAL

HS

HealthSource® Chiropractic
Progressive Rehab & Wellness®

Fax Transmittal Form

HealthSource of Brunswick
1659 Pearl Road
Brunswick, OH 44212

Phone: 330-220-6111
Fax: 330-220-6115
Web: www.DrsOrmsby.com
www.OurAngelsWithin.com

To: University Hospitals
Cleveland Medical Center
RE: Deborah A. Moss

From: Thomas Ormsby, D.C.

Date: March 22, 2017

FAX #: (216) 983-3038

- ☐ Urgent
- ☐ For Review
- ☐ Please Comment
- ☐ Please Reply

Attached please find the Return to Work Authorization for our patient Deborah A. Moss, DOB 05/31/65.

Please feel free to contact me with any questions.

CONFIDENTIAL

Cleveland Sight Center
Low Vision Clinic
1909 East 101st St.
Cleveland, OH 44106
Clinic:(216) 658-8737 Billing: 658-4554
Fax: (216) 658-8731

March 21, 2017

LOW VISION CLINIC REPORT

Patient Name: Debra A Moss **Salutation:** **Sex:** F **Date of Visit:** 03/21/2017
Date of Birth: 05/31/1965 **Age:** 51 **Ethnicity:** **Acct #:** 3016
Race: **Race 2:**
Primary Language: **Provider:** Lidija Balciunas
Patient Address: 63 Salem Court Hinckley, OH 44233
Location of Visit: Cleveland Sight Center/Low Vision Clinic

Tim Sullivan
OOD Akron,
161 S. High Street
Akron, OH 44308

Dear Mr. Sullivan,

I had the pleasure of seeing Ms. Debra Moss for a Low Vision Assessment on 03/21/2017. The following is a summary of my findings:

Visual Concerns	
Reading	Ms. Moss uses her CCTV or high powered reading glasses for reading tasks. Currently Ms. Moss has access to volunteers who read her work emails to her. She is a proficient Zoom text user and is hoping that the new UH software program that Parma hospital will be adopting will be able to accommodate Zoom Text. She has also reported difficulty reading labelled objects and itemized lists on cabinets and drawers. Ms. Moss has a Merlin CCTV at work, but it has poor contrast features as compared to the Topaz CCTV that she uses at home. She requests an upgraded Topaz CCTV for her work station. Ms. Moss also suffers from chronic neck and shoulder pain with associated structural changes in her spine related to the stress of using improper body mechanics while using her CCTV when reading and writing. Ms. Moss would benefit from an in-office assessment of CCTV height and workstation positioning to alleviate further unnecessary postural strain.
Mobility	Some mild issues with O&M related to when nurses or patients wear dark clothing which does not provide good contrast against the dark floors in the facility. Mostly this is reported as not much of a problem.
Vocational Issues	Ms. Moss works at UH as a recreation therapist on a geriatric psych floor. She was referred by her employer for a tier 1 mandatory fitness for duty evaluation for concerns about her physical performance and medical issues at the workplace. Ms. Moss has taken FMLA leave and has made appointments with her doctors. Her ophthalmologist referred her to the Cleveland Sight Center to address the functional questions the forms require. Ms. Moss is also working with Tim Sullivan in Akron's BSVI office to help get assistive aids and/or adaptations to improve certain functional tasks/requirements at work if possible. Ms. Moss reports that she has difficulty seeing patient's facial expressions, is sometimes unaware if someone is getting out of their seat, and has some difficulty reading work sheets.

Visual Acuities

	Unaided					Aided			
	Distance	EV	Near	EV		Distance	EV	Near	EV
OD	/		/			1 / 100		/	
OS	/		/			1 / 100		/	
OU	/		/			/		J16 /	

Visual Field (By Confrontation)

OD	Full	OS	OD
OS	Full		
OU			

Diagnosis And Plan

1 H54.0 Blindness, both eyes
Assessment: Visual impairment due to Stargardt's disease
Plan:
1 Tech assessment to evaluate scanners and potentially I-pad use (UH is considering implementing i-pads in the Behavioral center for older adults) where Ms. Moss works.
2. In-office assessment of CCTV workstation parameters to alleviate further postural strain and structural damage to the spine.
3. Tactile buttons / peel and press tabs for the copy machine at work
4. TOPAZ in-line CCTV with large monitor (model already selected)
5. 10x LED hand held magnifier for spot reading tasks

Recommended Low Vision aids, solutions and adaptations:

Device	Power	Intended use
*Magnifier (HH w/light)	10X	For spot reading recipes, Scanning mail, reading fit bit, checking the time and other spot reading tasks.

Notes:

Continue using 8x DVI microscopic readers OD, +24D binocular AOLITE microscopic reading glasses, in-line CCTVs, and ZoomText adaptive computer software. Looking into a scanner / reader may also prove beneficial.

Stargardt's disease is a condition that permanently diminishes central vision both distance and near. It does not affect peripheral vision and is not a blinding condition. It is a progressive condition, but Ms. Moss is not likely to get much worse at this point of the condition.

Referrals:

☐O.T.
☑CSC Social Worker
☐Counseling (TLC)
☐Orientation and Mobility
☐Rehabilitation Teacher

Referrals:
☐Employment Services ☐Back to MD ☐C.Y.A.S. ☐Assistive Technology ☐Peer Support ☐Diabetes Ed/Talking Glucometer

Please let me know if I can offer any further information. It has been a pleasure in participating in the care of this delightful patient.

Sincerely,

Signature: _____ Date: 03/21/2017

Lidija Balciunas, O.D.

CC: Georgene Kohlbacher, LISW-S, CEAP
Employee assistance program
11100 Euclid Ave.
Mail Stop 5035
Cleveland, 44106

Provider's name and business address: LIDIJA BALCIUNAS, OD 1909 E. 101ST ST CLEVELAND, OH 44106

Type of practice / Medical specialty: OPTOMETRIST CLEVELAND SIGHT CENTER

Telephone: (216) 658-8732 Fax: (216) 658-8731

2A. MEDICAL FACTS

Approximate date condition commenced: 1976 Probable Duration of condition: PERMANENT

Date(s) you have treated patient for condition in the past 12 months: N/A (LAST APPOINTMENTS: 3/21/17 AND 1/4/12

Was patient admitted for overnight stay in hospital, hospice or residential medical care facility? ___ Yes ✓ No
If yes, Inpatient Stay: (Date Admitted) ___/___/___

Will the Employee need to have treatment visits at least twice per year due to the condition? ___ Yes ✓ No

Was medication, other than over-the-counter medication, prescribed? ___ Yes ✓ No

Was the patient referred to other health care provider(s) for evaluation/treatment (e.g., physical therapist, specialist)?
___ Yes ✓ No. If so, state the nature and dates of such treatments and expected duration of treatment.

Is the medical condition pregnancy? ___ Yes ✓ No If yes, expected Date of Delivery: ___/___/___

If the employer provides a list of the employee's essential functions or a job description, answer these questions based upon that list. Otherwise, rely on the employee's own description of his/her job functions:

Is the employee unable to perform any of his/her job functions due to the condition: ✓ Yes ___ No If so, identify the job functions the employee is unable to perform: FACIAL RECOGNITION + EXPRESSIONS, SIGNING TREATMENT PLANS WHEN NOT NEAR CCTV SEEING IN POOR CONTRAST ENVIRONMENTS, MAY NOT ALWAYS HAVE VISUAL AWARENESS OF EVERYTHING GOING ON IN A ROOM. USES OTHER CUES TO GATHER INFORMATION

Describe the other relevant medical facts, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment) that are sufficient to establish the need for the patient to take leave (including any need for the intermittent absences or for work on a part-time or reduced schedule).

MS. DEBORAH MOSS WOULD LIKE TO CONTINUE WORKING — LEAVE WAS RECOMMENDED BY EMPLOYER

2B. AMOUNT OF LEAVE NEEDED (Single Continuous Period, Follow-up & Reduced Schedule, or Intermittent)

Single continuous period of incapacity
Will the employee be unable to perform some or all of his/her job functions for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___ Yes ___ No If so, provide the estimated beginning and ending dates for the period the employee is expected to be unable to perform some or all of his/her job functions: ___/___/___ to ___/___/___ THE VISUAL CONDITION IS PERMANENT + STABLE, NOT AN ~~ACTIVE~~ ACUTE CONDITION IN NEED OF TREATMENT FOR RECOVERY.

Follow-up or Part-time/Reduced Work Schedule
Will it be medically necessary for the employee to take leave to attend follow-up appointments and/or work part time or on a reduced schedule because of the medical condition: ___ Yes ___ No

WITH APPROPRIATE ADAPTATIONS, INCLUDING ACCESS TO TOPAZ CCTV HER SPECIALIZED GLASSES + ZOOM TEXT TALKING SOFTWARE, MS. MOSS MAY BE ABLE TO CONTINUE WORKING PART TIME WITH SUPPORT FROM OTHER STAFF MEMBERS WHEN NEEDED. ALL OF THE EMPLOYMENT RELATED VARIABLE ~~[illegible]~~ AND NECESSARY FACTORS CANNOT BE DETERMINED/ FULLY ASSESSED BY MY ASSESSMENT. VISUAL ACUITY IS SEVERELY REDUCED, BUT MS. MOSS HAS BEEN WORKING WITH THIS CONDITION FOR MANY YEARS IN HER CURRENT CAPACITY.

If so, provide information sufficient to establish the medical necessity for such leave: _____

If there is a medical necessity for follow-up treatment appointments, what is the estimated treatment schedule, including the date of any scheduled appointments and the amount of employee time off required for each appointment, including any recovery period:

FOLLOW UP APPOINTMENTS NOT INDICATED AT THIS TIME WITH ME.
MS. MOSS MAY NEED FOLLOW UP APPOINTMENTS WITH HER LSVI COUNSELOR TIM SULLIVAN

If there is a medical necessity that the employee work on a part-time or reduced schedule, estimate the part-time or reduced work schedule the employee needs: _____ hour(s) per day; _____ days per week from _____ through _____

Intermittent Leave MS. MOSS WORKS 24 HRS/WK 3 TIMES PER WEEK (3 DAYS EACH WEEK) AND FEELS COMFORTABLE WITH THAT SCHEDULE

Will the condition intermittently prevent the employee from performing some or all of his/her essential job functions? ____ Yes ____ No AS NOTED, CERTAIN JOB FUNCTIONS ARE CHALLENGING DUE TO LOSS OF CENTRAL VISION ... SUCH AS FACIAL RECOGNITION + EXPRESSIONS INTERPRETATION

If so, provide information sufficient to establish the medical necessity for such intermittent leave: _____

Based upon the employee's medical history and your knowledge of the medical condition, estimate the frequency and the duration of the employee's intermittent inability to perform some or all of his/her job functions over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode:

I AM UNABLE TO COMPLETE THIS PORTION IN THE MANNER REQUESTED

Estimated duration of the need for intermittent leave: _____

Signature of Physician/Practitioner: _____ Date: ___/___/___

Print Name: LIDIJA BALCIUNAS, OD Fax #: (216) 658-8731

Field of Specialization: LOW VISION OPTOMETRIST Phone #: (216) 658-8732

Address: 1901 E 101st St City/State/Zip: CLEVELAND OH 44106

Please review contact information below and fax this form to the appropriate team member based on the entity of employment:

Should you have any questions please call Disability Management Services at 216-767-8700 and follow the prompts to speak with a team member. Thank you.

ATTACHMENT A

Authorization for Release of Medical Information

University Hospitals

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records to be released from:
Case Medical Center ☐ Ahuja ☐ Bedford ☐ Conneaut ☐ Geneva ☐ Geauga ☐ Richmond ☐ UH Home Care ☐ UHPS ☐

Patient Name (Please Print): Moss (Last) Debra (First) MI

Date of Birth: 5/31/65 Social Security Number (last four digits)

Address: 63 Glen Ct Hinckley 44233 Phone Number: (330) 225 9587 Medical Record Number Prior MR #

Treatment Date(s): 2/16/17

Please Release Medical Information to the Following Recipient:
Name of Person or Organization: Primary Care Physician Dr. Paul Burns Phone
Address: 5673 Ridge Mailstop 4-886-3150 Fax #
City: Parma State Zip Code

Purpose of Disclosure: FFD Full ☐ at the patient's request

Description of Information to be Released:

☐ Pertinent Summary (includes all * items)
☐ Admission Form
☐ *Discharge Summary
☐ *Emergency Room Report
☐ *History & Physical
☐ *Consultation Report
☐ *Operative Report
☐ Facesheet / Demographics
☐ Lab Reports
☐ *Radiology Report
☐ *EKG Report
☐ *Pathology Report
☐ *Card Cath Report
☐ Physical Therapy
☐ Entire Record
☐ Physician's Notes
☑ Other: Coordination, tx, uca for FFD

I, the undersigned, authorize UH EAP Caroline Coolhall (disclosing institution) and its employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: 1 yr signed date. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand there may be charges for the copying and release of information and accept financial responsibility.

X Debra Moss 2/16/17
Signature of Patient/Legal Representative — Date Signed

☐ Patient unable to sign
Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

*If other than patient's signature, a copy of legal documents MUST accompany this authorization when presented; the exception is a parent of minor (under 18 years of age).

HIM13016
SP13016 Authorization for Release of Medical Information (1/11) 601233

Patient ID Label

GM-61 – Accessing Protected Health Information
Owner: Health Information Management
Revised: March 2011
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Uncontrolled document – printed version only reliable for 24 hours